

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05908

CERTIFICATE OF DEATH

05905

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CRUMPTON	c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL

3. NAME OF DECEASED (Type or print)	First SARAH	Middle ELIZABETH	Last BLACKISTON	4. DATE OF DEATH APRIL	Month 4	Day 1966	Year		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED	8. NEVER MARRIED X	9. DATE OF BIRTH AUG. 12-1877	9. AGE (in years last birthday) 88 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME ALFRED WALBERT	14. MOTHER'S MAIDEN NAME MARY E. COPPER	15. ADDRESS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	Paroxysmal Convulsive seizures Chronic myoclonic Paroxysm
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 2	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2	20f. (City or town) 2	(County) 2	(State) 2
---	--	---	---	--	---------------------------------	----------------------	---------------------

21. I certify that (I) (this hospital) attended the deceased from **Aug 1, 1966**, to **April 4, 1966**, that (I) (we) last saw the deceased alive on **Aug 1, 1966**, and that death occurred at **4201** M., from the causes and on the date stated above.

22a. SIGNATURE C. H. Metcalfe	22b. DATE SIGNED 4/5/66
22c. PHYSICIAN'S NAME (Type) C. H. Metcalfe	22d. ADDRESS SUDLERSVILLE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 7	23c. NAME OF CEMETERY OR CREMATORIAL Wesley CHAPEL	23d. LOCATION (City, town or county) Rock Hall MD.	(State) MD.
24. FUNERAL DIRECTOR Edgar F. Lane	ADDRESS CHURCH HILL MD.	25a. REC'D BY REGISTRAR APR 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07476

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *(Signature)*
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/6

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Queen Anne rural Centerville life		a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
rural Centerville life		d. STREET ADDRESS <u>rural Centerville, Md.</u> 17-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Thomas</u>	Middle <u>Franklin</u>
4. DATE OF DEATH		Month <u>4</u>	Day <u>13</u>
5. SEX		6. COLOR OR RACE <u>Male Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) <u>59 yrs.</u>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Queen Anne, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Gauld</u>		14. MOTHER'S MAIDEN NAME <u>Perretta Larley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-6741</u>	
17. INFORMANT <u>Evelyn Gauld</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		4 years	
} DUE TO (c) <u>Disseminated Lupus Erythematosus</u>		3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 13, 1962</u> , to <u>Apr. 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Apr. 13, 1966</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J.R. Smith, Jr.</u>		22b. DATE SIGNED <u>April 16, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr. M.D.</u>		22d. ADDRESS <u>Centerville, Maryland</u>	
23a. BURIAL, CREMATION REMAINDER (Specify) <u>Burial 4 15-66</u>		23b. DATE THEREOF <u>15-66</u>	
23c. NAME OF CEMETERY OR CREMATORIAL <u>Gauldtown Cemetery</u>		23d. LOCATION (City, town or county) <u>Queen Anne Md.</u> (State) <u></u>	
24. FUNERAL DIRECTOR <u>James B. Nashell</u>		25a. ADDRESS <u>Easton, Md.</u>	
25b. REC'D BY REGISTRAR <u>Charles J. George</u>		25c. REGISTRAR'S SIGNATURE <u>Charles J. George</u>	
DATE MAY 16 1966			

with high altitude
atmospheric pressure

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05909

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please enclose the certificate, striking the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

05909

1. PLACE OF DEATH a. COUNTY <i>QUEEN ANNE'S</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL QUEENSTOWN</i>		c. LENGTH OF STAY IN 1b <i>Instant</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Hospital 301</i>		e. STREET ADDRESS <i>R.D. #1</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	Lee	First	CONDIER	Middle	HAAS	Last	4. DATE OF DEATH	
	<i>Lee Linda Haas</i>					Month	Day	Year
						April	9	1966

5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Feb. 11 1933</i>	9. AGE (in years last birthday) <i>33 yrs.</i>	10. IF UNDER 1 YEAR Months <i>1309</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. IF UNDER 24 HRS. Min. <i>0</i>
--------------------	------------------------------	--	---	---	--	--	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Builder</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
---	---	--	---

13. FATHER'S NAME <i>Webster N Haas</i>	14. MOTHER'S MAIDEN NAME <i>Florence Smith</i>
--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	16. SOCIAL SECURITY NO. <i>24-30-8770</i>	17. INFORMANT <i>Syland Haas Sannally</i>	Address <i>1309 W. Market St. Gary, Ind.</i>
---	--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<i>8164</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO			
(c)			
Multiple + Extreme Head Injury			
Instant			
INTERVAL BETWEEN ONSET AND DEATH			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<i>Fracture of both legs</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Head on auto collision</i>		
--	---	--	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>5:25</i> p.m. <i>7-17 1966</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>Queenstown QA Md</i>	(County) <i>QA</i>	(State) <i>Maryland</i>
--	--	---	--	-----------------------	----------------------------

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
--	--	--	--	--	--

ACTUAL SIGNATURE <i>C.R. Layton</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>4-12-66</i>	
EXAMINER'S NAME (Type) <i>C.R. Layton</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	Centreville Md		

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Apr. 12/66</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chesapeake Cemetery</i>	22d. LOCATION (City, town, or county) <i>Chesapeake Maryland</i>	(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin B. Williams - Chesapeake Md</i>	ADDRESS <i>Chesapeake Md</i>	24a. REC'D BY REGISTRAR <i>APR 14 1966</i>	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

THE FEDERAL BUREAU OF INVESTIGATION - U. S. DEPARTMENT OF JUSTICE
MEDICAL EXAMINER - CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05910

CERTIFICATE OF DEATH

05910

1. PLACE OF DEATH
a. COUNTY *Queen Anne* MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Rural Chestertown*
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE *Maryland* b. COUNTY *Queen Anne*
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Rural Chestertown*
d. STREET ADDRESS

3. NAME OF DECEASED (Type or print) *Mary Elizabeth Jester* 4. DATE OF DEATH *April 2 1966*
First Middle Last Month Day Year

5. SEX *Female* 6. COLOR OR RACE *White* 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH *July 16, 1892* 9. AGE (In years last birthday) *73* yrs.
WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Housewife* 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) *Maryland* 12. CITIZEN OF WHAT COUNTRY? *USA*

13. FATHER'S NAME *John H. Burchard* 14. MOTHER'S MAIDEN NAME *Alice Wiggins*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) *Yes* 16. SOCIAL SECURITY NO. *17. INFORMANT* *Franklin Jester - Chestertown, Md. RFD* Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) *Acute Cardiac Dilatation* INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) *Chronic Myocarditis*
DUE TO *General Arterial Disease*
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *Senility*
DUE TO *Senile*
(c) *Senile*

19. WAS AUTOPSY PERFORMED? YES NO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) *Senility*

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) *W*

20c. TIME OF INJURY Month, Day, Year *April 1966* 20d. INJURY OCCURRED *While at work* 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *Sudlersville* 20f. (City or town) *Sudlersville* (County) *Maryland* (State) *Maryland*

21. I certify that (I) (this hospital) attended the deceased from *July 1, 1966* to *April 2, 1966* that (I) (we) last saw the deceased alive on *April 1, 1966*, and that death occurred at *9 AM* from the causes and on the date stated above.

22a. SIGNATURE *C. H. Metcalfe* 22b. DATE SIGNED *4/4/66*

22c. PHYSICIAN'S NAME (Type) *C. H. Metcalfe* M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22d. ADDRESS *Sudlersville, Maryland*

23a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 23b. DATE THEREOF *April 5* 23c. NAME OF CEMETERY OR CREMATORIAL *Crumpton* 23d. LOCATION (City, town or county) (State) *Crumpton, Maryland*

24. FUNERAL DIRECTOR ADDRESS *Edgar S. Lane Church Hill, Md.* 25a. REC'D. BY REGISTRAR DATE *APR 11 1966* 25b. REGISTRAR'S SIGNATURE *Charles Judge*

EDT 11 1964

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
05911 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05908

1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>	COUNTY <i>Queen Anne</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Price</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Price</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>000</i>		d. STREET ADDRESS <i>17-1</i>	

3. NAME OF DECEASED (Type or print) <i>Eva</i>	First	Middle <i>Virginia</i>	Last <i>Kimbles</i>	4. DATE OF DEATH <i>April 8 1966</i>	Month Day Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1892</i>	9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Q.A. Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Loda Anderson</i>		14. MOTHER'S MAIDEN NAME <i>Anna Neuman</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <i>John S. Kimbles-Price, Maryland</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: <i>Arteriosclerotic cardiovascular disease</i>		<i>several years</i>	
IMMEDIATE CAUSE (a) <i>4221</i>		DUE TO	
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.		(b)	
		DUE TO	
		(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
Hour a.m. p.m.	19	White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					

21. I certify that (I) (this hospital) attended the deceased from <i>1/14</i> , 19 <i>63</i> , to <i>4/8</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/8</i> , 19 <i>66</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.							
---	--	--	--	--	--	--	--

22a. SIGNATURE <i>Robert W. Farr</i>	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED <i>4/11/66</i>
---	---	------------------------------------

22c. PHYSICIAN'S NAME (Type) <i>Robert W. Farr</i>	22d. ADDRESS <i>Chestertown, Maryland</i>
---	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>April 12</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Church Hill</i>	23d. LOCATION (City, town or county) (State) <i>Church Hill, Maryland</i>
--	--------------------------------------	--	--

24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>	ADDRESS <i>Church Hill, Maryland</i>	25a. REC'D BY REGISTRAR <i>APR 18 1966</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
--	---	---	--

4037

2020

2020-2021

2020-2021

2020

2020-2021

2020

2020-2021

2020-2021

2020-2021

2020-2021

2020-2021

2020-2021

2020-2021

2020

2020

2020-2021

2020-2021

2020-2021

2020-2021

2020-2021

2020-2021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <i>QUEEN ANNE'S</i>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>RURAL Queenstown</i>			c. LENGTH OF STAY IN 1b <i>32 yrs.</i>			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <i>Maryland</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Queenstown</i>			d. STREET ADDRESS <i>17-1</i>			b. COUNT <i>QUEEN ANNE'S</i>					
3. NAME OF DECEASED (Type or print) <i>Chester Gilmore Lawrence</i>			First <i>Chester</i>	Middle <i>Gilmore</i>	Last <i>Lawrence</i>	4. DATE OF DEATH <i>April 4 1966</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <i>Male</i>			6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 28, 1908</i>	9. AGE (in years at last birthday) <i>57 yrs.</i>			10. IF UNDER 1 YEAR Months <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>County Roads Comm.</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Pittsburgh, Pennsylvania</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>William J. Lawrence</i>			14. MOTHER'S MAIDEN NAME <i>Martha Gilmore</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>28-20-5707</i>					
17. INFORMANT <i>John W. Lawrence</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>Acute Coronary Occlusion</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Address <i>Route 5 Parker Road, Salisbury, Maryland</i>					
DUE TO (b) DUE TO (c)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Disseminated Atherosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>			? yrs.					
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>March 19</i>			20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1964</i> to <i>March 1966</i> , that (I) (we) last saw the deceased alive on <i>May 30 1966</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			22a. SIGNATURE <i>Irvin G. Hoyt</i>			22b. DATE SIGNED <i>4/4/66</i>			22c. PHYSICIAN'S NAME (Type) <i>Irvin G. Hoyt M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>Queenstown, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>April 6, 1966</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Wicomico Memorial Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>					
24. FUNERAL DIRECTOR <i>James H. Baileys Jr. Baileys Bros. Centerville, Md.</i>			ADDRESS			25a. REC'D BY REGISTRAR <i>APR 11 1966</i>			25d. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05913

CERTIFICATE OF DEATH

05910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lucillia	Middle Rich	4. DATE OF DEATH April 18, 1966
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH About 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Claymon Rich	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	16. SOCIAL SECURITY NO.	17. INFORMANT Cornelius Sewell - Stevensville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic arteriosclerotic heart disease, glars DUE TO OUE TO (c) with Decompensation, Arteriosclerotic glars PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) seriously			
INTERVAL BETWEEN ONSET AND DEATH April 18, 1965			
20a. ACCIDENT WAS UNDERTHLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from April 10, 1966, to April 18, 1966, that (I) (we) last saw the deceased alive on April 10, 1966, and that death occurred at 74 M, from the causes and on the date stated above.			
22a. SIGNATURE Theodore Sattelmaier		22b. DATE SIGNED April 19, 1966	
22c. PHYSICIAN'S NAME (Type) Theodore Sattelmaier		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 20	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Wesley		23d. LOCATION (City, town or county) No. Stevensville, Md. (State)	
24. FUNERAL DIRECTOR Edgar L. Lane		25a. REC'D BY REGISTRAR APR 25 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

